Nevada Rural Hospital Flexibility Program

Checklist for the Medicare Critical Access Hospital (CAH) Certification Survey

Please direct questions or comments about this checklist to:

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Overview of the Checklist for the Medicare Critical Access Hospital (CAH) Certification Survey

The following checklist draws on a number of existing documents including the interpretive guidelines for surveyors developed and revised by CMS, the Idaho self-audit tool developed by the Idaho Hospital Association, Nevada Administrative Code (NAC) Chapter 449, communications with the Nevada Bureau of Licensure and Certification, mock survey tools prepared by the Nevada Office of Rural Health and the Nevada Rural Hospital Partners.

This checklist or tool is designed for use by hospital administrators and staffs to ensure that they are as prepared as possible for the initial survey their hospital will undergo as part of the CAH application process. This checklist is also updated periodically – as changes in federal and state regulations take place – and is thus useful for CAH re-surveys. The tool is structured to conform to the interpretive guidelines which surveyors will use in evaluating CAH applicant hospitals.

The checklist can also be used to see if the required standards are met or whether corrective action is needed. It is suggested that the tool be parceled out to the appropriate departments which can then report on their status in terms of meeting the outlined requirements.

The tool is divided into four columns, as follows:

- The first column (*Tag*) provides the number of the specific interpretive guideline which the surveyors use for this section.
- The second column (*Regulation*) lists the specific regulation which applies to that area.
- The third column (*Elements to Consider*) is our interpretation of the items the hospital must assess to ensure that the standards for that regulation are met. These "elements" were derived from the guidance to surveyors. In most cases, the context of the guidance was altered to make it read more appropriately for a "self check."

  Notes or cautionary language has been added in areas which may present problems. These notes include changes in regulations and rules, as well as changes in the interpretation of such rules and regulations. The Nevada Office of Rural Health will forward notices of such changes to all rural hospitals in the process of Critical Access Hospital designation as soon as such notices are received.

  In some places you are asked to "see policy" or "see sample agreement" – these sample policies and agreements are contained in the accompanying appendix: *Nevada Rural Hospital Flexibility Program: Sample Agreements and Assurance Documents for the Critical Access Hospital Certification Survey*.

- The fourth column (*Evidence/Surveyors' Focus*) indicates the types of evidence and focus undertaken by surveyors to determine compliance with standards and conditions. As such, this column services as a checklist for corrective action and steps which needs to be taken prior to the survey.

Although not specifically addressed in CAH regulations, nor in this tool, it is noted that hospitals also must be in compliance at the initial survey with federal regulations pertaining to advance directives, criminal background checks, and EMTALA.

As you proceed through this checklist and in anticipation of the certification survey, you and your staff should begin assembling the following materials (most are discussed in the detailed checklist below):

☐ Hospital policies and procedures covering all CAH statutory requirements, such as:

- CAH Pharmacy Department Policies and Procedures Manual
- CAH Laboratory Department Policies and Procedures Manual
- CAH Emergency Department Policies and Procedures Manual
- CAH Medical Records Policies and Procedures Manual
- CAH Nursing Department Policies and Procedures Manual
- CAH Dietary Policies and Procedures Manual
- CAH Physical Plant and Maintenance Policies and Procedures Manual
- CAH Organ, Tissue, and Eye Procurement Policies and Procedures Manual
- CAH HIPAA Compliance Manual

☐ List of services the hospital provides directly

☐ List of services the hospital provides indirectly through arrangements or agreements

☐ Copy of all service agreements and network agreements including participation in a communication system, physician coverage (if applicable), and referral, admission, and transportation of patients

- CAH Agreements and Contracts Binder

☐ CAH Periodic Evaluation and Quality Assurance Plan, including CAH QA/QI meeting agenda and minutes

☐ Hospital organizational chart and position descriptions for all levels of personnel – note: the organization chart should highlight, where applicable, the lines of authority within the distinct acute care, long-term care, and clinic operations of the facility

- CAH Organizational Chart
- CAH Job Description Binder

☐ Staffing schedules for hospital emergency departments, outpatient/clinic department, and other units for the past three months

☐ On-call schedules for physicians and other staff (e.g., mid-level providers, laboratory personnel, imaging) for the past three months

☐ Hospital personnel files with evidence of appropriate licensure, certification, and/or registration

☐ Credentials files for physicians and mid-level providers

☐ Hospital committee meeting minutes for the past year

- CAH Infection Control Committee
- CAH Periodic Evaluation and Quality Assurance Committee
- CAH Policies and Procedures Committee

☐ Hospital governing body or board meeting minutes for the past year

- CAH Bylaws
- CAH Administrative Policies and Procedures Manual

- CAH Personnel Policies and Procedures

☐ Hospital infection control log

☐ Incident reports for the past year

☐ Hospital utilization review reports and follow-ups for the past year

☐ Menus for one month for all diets offered at the hospital

☐ Current and closed medical records, including records for swing bed patients, if applicable – the surveyors will request specific records during the survey

☐ Admission, discharge, and transfer information

☐ Emergency room logs for the past year

In conclusion, it must be emphasized that your facility is probably already in compliance with most of the regulations listed in this checklist, since many of these same regulations are required for licensure by the State of Nevada. Hospital administration and staff likely possess most of the documentation and assurances needed for CAH designation. Nevertheless, the purpose of the CAH survey process is to evaluate your facility's compliance with each of the conditions of participation in the most efficient manner possible.

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Checklist for the Medicare Critical Access Hospital Certification Survey

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C150	**§485.608 Condition of participation: Compliance with Federal, State, and local laws and regulation.** The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.	Is your facility in compliance with EMTALA, PSDA, and SMDA regulations? See all applicable regulations contained in Nevada Administrative Code (NAC) Chapter 449, NAC 449.363	Pre-survey research + compliance previously determined by the Nevada Office of Rural Health (NORH).
C151	(a) Standard: Compliance with Federal laws and regulations. The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.	Is your facility in compliance with applicable Federal laws and regulations related to the health and safety of patients?	Pre-survey research + compliance previously determined by the NORH.
C152	(b) Standard: Compliance with State and local laws and regulations. All patient care services are furnished in accordance with applicable State and local laws and regulations.	Are all state mandated policies and procedures in place? See NAC Chapter 449. Note: As a CAH your hospital is not subject to some hospital regulations, but if your hospital is applying for status as CAH surveyors may take the position that on date of survey you must meet all then existing conditions. See sample policy C152	Pre-survey research + compliance previously determined by the NORH. BLC will determine what professional specialists (i.e., physicians, mid-level providers) provide patient care services at the facility and review Nevada practice act requirements (e.g., supervision requirements).
C153	(c) Standard: Licensure of CAH. The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.	See all applicable chapters contained in NAC Chapter 449.	Generally not a focal concern unless the facility is currently not licensed by the State of Nevada.
C154	(d) Standard: Licensure, certification or registration of personnel. Staff of the CAH are licensed, certified, or registered in accordance with applicable State and local laws and regulations.	Does your hospital have current licenses or verification of current licenses for all licensed personnel in the personnel files? Are required fingerprint and reference checks on file? Have clearances been obtained from the Nevada Highway Patrol? See sample policy C154	Written documentation and review of policies and procedures: ☐ Binder – CAH Job Descriptions ☐ Current personnel files and staff licensure ☐ Personnel files are in compliance with facility and state policy ☐ CAH Personnel Policies and Procedures Manual

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C160	**§485.610 Condition of participation: Status and Location**.	This COP only applies to initial surveys.	Pre-survey research + compliance previously determined by the NORH.
C161	(a) Standard: Status. The facility is a public or nonprofit hospital. The facility is – (1) A currently participating hospital that meets all COPs set forth in this subpart; (2) A recently closed facility, provided that the facility (i) was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and (ii) meets the criteria for designation under this subpart as of the effective date of its designation; or (3) A health clinic or health center (as defined by the State) that (i) is licensed by the state as a health clinic or health center; (ii) was a hospital that was downsized to a health clinic or a health center; and (iii) as of the effective date of its designation, meets the criteria for designation set forth in this subpart.	Note: This regulation has changed per the BBRA (1999) – for profit hospitals are also eligible.	Pre-survey research + compliance previously determined by the NORH.
C162	(b) Standard: Location. The CAH meets the following requirements – (i) The CAH is located outside any area that is a MSA as defined by the OMB; (ii) The CAH is not deemed to be located in an urban area under §412.63(b) of this chapter; and (iii) The CAH has not been classified as an urban hospital for the purposes of the standardized payment amount or by the CMS Medicare Geographic Classification Review Board.	Note: NORH has already determined that your facility meet this condition per your hospital's completion of the "Preliminary Application for Eligibility Determination." This condition generally does not affect any Nevada rural hospitals, yet some facilities are located in urban counties (Mesquite, Incline Village) and metropolitan counties (Tonopah, Pahrump) as defined by federal agencies.	Pre-survey research + compliance previously determined by the NORH.
C165	(4) The CAH is located more than a 35 mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15 mile drive) from a hospital or another CAH, or the CAH is certified by the State as being a necessary provider of health care services to residents in the area.	Note: NORH has already determined that your facility meet this condition per your hospital's completion of the "Preliminary Application for Eligibility Determination." One may reasonably consider a road "secondary" if it is not an Interstate, U.S., or State highway. See the *Nevada Rural Health Plan* for information and applications for designation as a "Necessary Provider of Health Care Services" by the NORH	Pre-survey research + compliance previously determined by the NORH.

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C170	**§485.612 Condition of participation: Compliance with hospital requirements at time of application.** The hospital has a provider agreement to participate in the Medicare program as a hospital applies for designation as a CAH.	This COP applies only to initial surveys This is an important condition. Be sure that you can demonstrate corrective action has been taken with regards to any deficiencies under old conditions of participation. NORH will assist your facility with a review of your last survey report, plan of correction, and follow-ups.	Written documentation: ☐ Provider agreement on file ☐ Review last SOD ☐ Corrections made/implemented per last POC
C190	**§485.616 Condition of participation: Agreements**.	What kind of agreement/system is set up to handle communications with transfer hospital? What about "back-up" systems? If your facility does not have a hospital-based SNF, do you have transfer agreements with another SNF? See sample agreements C190 and C192	Written documentation & review of policies & procedures: ☐ Binder – CAH Agreements and Contracts
C191	(a) Standard: Agreements with network hospitals In the case of a CAH that is a member of a rural health network as defined in §485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for –	Section 485.603 defines a rural health network as an organization that includes at least one hospital that the State has designated or plans to designate as a CAH, and at least one hospital that furnishes acute care (hospital) services. How does or will the CAH participate with other hospitals or facilities in the network communication system? Is a communication log kept at the facility? Are there any difficulties in contacting network members? How are such difficulties dealt with? See sample agreements C190 and C192	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Documentation of membership in NRHP Interviews with staff
C192	(1) Patient referral and transfer;	See sample agreements C190 and C192	Written documentation: ☐ Binder – CAH Agreements and Contracts

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C193	(2) The development and use of communication systems of the network, including the network's system for the electronic sharing of patient data; and telemetry and medical records, if the network has in operation such a system; and	How does the CAH participate with other hospitals and facilities in the network communications system? Is a communications log kept at the facility? Ask staff if there have been difficulties in contacting network members. If so, ask how the CAH deals with communications delays. What evidence demonstrates that CAH staff can operate communications equipment? How does the network's communications system compare with any online and available communications equipment in the CAH? When the network communications system is down how does the CAH communicate and share patient data with network hospital? See Sample Communications Agreement Between NORH/University of Nevada School of Medicine (UNSOM) and CAH (C193)	Written documentation: ☐ Agreement on file ☐ Communications log ☐ Backup system in place
C194	(3) The provision of emergency and non-emergency transportation among the facility and the hospital.	See sample agreement between CAH and local EMS provider (C194) See also NAC 449.331	Written documentation: ☐ Agreement between CAH and local EMS service on file
C195	(b) Standard: Agreement for credentialing and quality assurance. Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least – (i) One hospital that is a member of the network; or (ii) One QIO (formerly PRO) or equivalent entity; or (iii) One other appropriate and qualified entity identified in the State rural health care plan.	Surveyors will review any agreements related to credentialing or quality assurance to determine the level of assistance to be provided and the responsibilities of the CAH. **Note: To date, all Nevada facilities have entered into an agreement with BETA Healthcare Group of Alamo CA to meet this requirement. Those facilities that have not chosen to use BETA must have another "appropriate and qualified entity" approved by the Nevada FLEX Committee. During the calendar year 2004, the Nevada FLEX Committee will revise the provisions by which CAHs meet this standard.** See sample agreements C195 See also NAC 449.3628	Written documentation: ☐ Agreement on file ☐ Documentation of follow-ups by identified entity

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C200	**§485.618 Condition of participation: Emergency services**. The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.	Surveyors will review all policies and procedures for emergency services. Review a sample of patient records for the emergency department. Is your hospital able to demonstrate appropriate care following emergency department policies and procedures? Are all the statutorily required policies and procedures in place? See also NAC 449.327, NAC 449.331, NAC 449.349	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures ☐ Review of open and closed patient records Facility inspection Interviews with staff
C201	(a) Standard: Availability. Emergency services are available on a 24-hour basis.	Is there a qualified practitioner available 24-hours a day? Can that person be at the hospital within 30 minutes? Are required equipment, supplies and medications always readily available? Qualified practitioner need not be a doctor of medicine or osteopathy This practitioner could be NP or PA with the hospital's governing body's agreement. EMTALA is still a requirement for CAHs See sample policy C201	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures ☐ ER log for the past year ☐ Review of open and closed patient records Facility inspection Interviews with staff, patients, and families and/or observations as applicable
C202	(b) Standard: Equipment, supplies, and medication. Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:	How does your facility ensure that the required equipment, supplies, and medications are always readily available in the CAH?	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures Inspection/tour of the Emergency Room Interviews with staff
C203	(1) Drugs and biologicals commonly used in life saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.	Are appropriate drugs and biologicals available to the staff at all times? Is an inventory maintained? Do all hospital staff know how to access required drugs and biologicals 24 hours a day? See also NAC 449.343	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures Inspection/tour of the Emergency Room Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C204	(2) Equipment and supplies commonly used in life saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquet, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.	Are equipment and supplies required at §485.618(b)(2) readily available? Does the staff know where emergency equipment and supplies are kept? Who is responsible for monitoring supplies? How are supplies replaced? When was the last time emergency supplies were used? Is there an equipment maintenance schedule, (e.g., for the defibrillator)? Are pediatric equipment and supplies available? Sterilized equipment will be examined. Functional capabilities of the oxygen supply systems will be assessed. The operating condition of the vacuum (suction) equipment will be checked.	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures Inspection/tour of the Emergency Room Interviews with staff

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C205	(c) Standard: Blood and blood products. The facility provides, either directly or under arrangements, the following – (1) Services for the procurement, safekeeping and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hour-a-day basis.	Blood is either stored on-site under appropriate conditions or the facility has a process in place to get a patient to a site where blood is available. Are blood and blood products accessible to staff in time to effectively treat emergency patients? Is there an effective system of making blood products available to its emergency patients 24-hours-a-day in place? Either type and cross match are available 24-hours-a-day or there is always on hand four units of universal O negative packed red cells. If universal donor is stored on site, is there an arrangement with blood bank to rotate and replace? This requirement can be met by a CAH by providing blood or blood products on an emergency basis at the CAH, either directly or through arrangement, if that is what the patient's condition requires. There is no requirement in the regulation for a CAH to store blood on site, although it may choose to do so. In some cases, it may be more practical to transport a patient to the source of blood supply than to bring blood to the patient at the CAH. A facility which has the capability of providing blood services on site would be in compliance with this standard even if, in virtually all cases, the patients were actually taken to the blood rather than vice versa. A CAH that stores blood on site will be surveyed under CLIA if tests subject to CLIA are conducted on the blood. A CAH that is only storing blood for transfusion and refers all related testing out to another laboratory is not performing testing as defined by CLIA. However, under this regulation, it must ensure that blood is appropriately stored to prevent deterioration, including documenting refrigerator temperatures. The provision of blood services between the CAH and the testing laboratory should be reflected in the written agreement or arrangement between the two. Also, if the CAH is collecting blood, it must registered with the FDA. See sample policy C205 See also NAC 449.373, NAC 449.3735	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures ☐ Binder – CAH Laboratory Department Policies and Procedures ☐ Binder – CAH Agreements and Contracts – esp., a signed agreement with pathologist and it details his/her responsibilities. ☐ Refrigerator temperature logs Inspection/tour of the Emergency Room Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C206	(2) Blood storage facilities that meet the requirements of 42 CFR part 493, Subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the person directly responsible for the operation of the facility.	If blood banking services are provided on-site, what evidence shows that the blood facility is under control and supervision of a pathologist or other qualified doctor of medicine or osteopathy? For blood banking services provided under arrangement, what evidence shows that the CAH medical staff and the person responsible for CAH operations have approved the arrangement?	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures ☐ Binder – CAH Laboratory Department Policies and Procedures ☐ Binder – CAH Agreements and Contracts – esp., a signed agreement with pathologist and it details his/her responsibilities. Inspection/tour of the Emergency Room Interviews with staff
C207	(d) Standard: Personnel (1) Except as specified in paragraph (d) (2) in this section, there must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training or experience in emergency care on-call and immediately available by telephone or radio contact, and available on-site (i) within 30 minutes on a 24-hour-a-day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section – or – (ii) within 60 minutes, if all of the following requirements are met: (A) the CAH is located in an area designated as a frontier area (i.e., an area with fewer than six residents per square mile based on the latest population data published by the Bureau of Censes); (B) the State has determined under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing care to residents of the area served by the CAH; and (C) the State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.	How does staff ensure that a doctor of mid-level provider is on call 24-hours-a-day and available on-site at the CAH within 30 minutes? Could any staff person at any time determine who the on-call person is? Is there evidence from documentation reviews that the 30 minute on-call requirement has been met? Expect the surveyors to show up at the hospital at any hour of the day to test this requirement! The person at the hospital makes the determination as to whether or not practitioner must come in. The "on call" practitioner does not. **Note: Any exceptions to this standard must be submitted in writing to the Nevada FLEX Program, the Bureau of Licensure and Certification, and documented with the Nevada Office of Rural Health. The Nevada Rural Health Plan does not currently provide any exception to this standard.** See sample policy C207 See also NAC 449.358, NAC 449.363	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures ☐ Binder – CAH Agreements and Contracts ☐ Credentials files ☐ ER log ☐ On-call schedules Interviews with staff, patients, and families and/or observations as applicable Interviews with local officials (e.g., local volunteer rescue services, 911 dispatch services, local government, etc) to determine if there have been any instances when a properly trained or experienced CAH practitioner has not been available by telephone or at the CAH within 30 minutes

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C207 continued	(2) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if – (i) the CAH has no greater than 10 beds; (ii) the CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(ii)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the State. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section; and (iv) once a Governor submits a letter, as specified in paragraph (d)(2))(ii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of personnel in the area, to provide adequate coverage as specified in this paragraph (d). (3) The request, as specified in paragraph (d)(2)(ii) of this section, and the withdrawal of the request, may be submitted to CMS at any time, and are effective upon submission.		
C209	(e) Standard: Coordination with emergency response systems. The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hour-a-day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.	The hospital has in place a system to immediately put a doctor of medicine or osteopathy in communication with emergency responders. Note: This is a requirement for the hospital, not the ambulance service or local emergency response system. This requirement contemplates that the doctor from his residence or from someplace outside the hospital could make this contact as well as from the hospital What records will demonstrate that the procedures are followed and evaluated? See sample policy C209 and sample agreement C194	Written review & documentation of policies & procedures: ☐ Binder – CAH Emergency Department Policies and Procedures ☐ Binder – CAH Agreements and Contracts ☐ ER log Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C210	**§485.620 Condition of participation: Number of beds and length of stay.**	Note: NORH has already determined that your facility meets this condition per your hospital's completion of the "Preliminary Application for Eligibility Determination."	Pre-survey research + compliance previously determined by the NORH.
C211	(a) Standard: Number of beds. Except as permitted for CAHs having swing-bed agreements under §485.645 of this chapter, the CAH maintains no more than 25 inpatient beds.	This provisions was changed with legislation passed by Congress in 2003 allowing CAHs to allocate 25 acute care beds, including swing beds.	Pre-survey research + compliance previously determined by the NORH. Initial facility inspection
C212	(b) Standard: Length of stay. The CAH provides acute inpatient care for a period that does not exceed, on an average annual basis, 96 hours per patient.	Note: The 96 hour rule is an "average" not per individual patient. Be prepared to demonstrate at you next survey that your average length of stay was not over 96 hours. You need no longer seek waiver from the PRO for patients whose expected length of stay will be over 96 hours.	Written review & documentation of policies & procedures: ☐ Binder – CAH Policies and Procedures ☐ Current monthly log of inpatient length of stay ☐ Utilization review reports
C220	**§485.623 Condition of participation: Physical plant and environment.**	See also NAC 449.3154-5, NAC 449.316	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures Facility inspection Interviews with staff
C221	(a) Standard: Construction. The CAH is constructed, arranged, and maintained to ensure access to and safety of patients and provides adequate space in the provision of direct services.	During the tour of the facility, surveyors will observe your facility to determine and ensure that this condition is met. See also NAC 449.3154, NAC 449.3156, NAC 449.316	Facility inspection to observe direct serve areas for adequate space to ensure patient safety and to facilitate the provision of direct services (i.e., patient examination and treatment areas, laboratory, radiology, and emergency services) Interviews with staff
C222	(b) Standard: Maintenance. The CAH has housekeeping and preventive maintenance programs to ensure that: (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;	Are there maintenance records on any unsafe mechanical equipment (e.g., boiler equipment, kitchen refrigerator/freezer, laundry equipment) in evidence? Does the hospital meet 1985 Life Safety Codes? See also NAC 449.316	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Maintenance records Facility inspection Interviews with staff

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C223	(2) There is proper routine storage and prompt disposal of trash;	Is trash, including contaminated materials, stored and disposed of promptly and properly? Does the storage and disposal of trash conform with state licensure regulations?	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Maintenance records Facility inspection – inside and out Interviews with staff
C224	(3) Drugs and biologicals are appropriately stored;	What standards or guidelines does your facility follow to ensure that drugs and biologicals are appropriately stored (e.g., esp., "locked")? See also NAC 449.373	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Binder – CAH Pharmacy Department Policies and Procedures Facility inspection Interviews with staff
C225	(4) The premises are clean and orderly; and	This is a self-explanatory, yet essential issue that must be addressed prior to the certification survey. "Clean and orderly" means an uncluttered physical environment where patients and staff can function safely (e.g., equipment and supplies stored in proper spaces, not in corridors, spills not left unattended or identified, no floor obstructions). "Clean and orderly" also means that the facility is neat and well kept (e.g., no peeling paint, visible water leaks, plumbing problems).	Facility inspection Interviews with Staff
C226	(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	What recommendations, standards, or guidelines does the CAH use to determine appropriate levels of ventilation, lighting, and temperature control? Will maintenance records show repeated difficulties in ventilation, lighting, and temperature control without effective resolution?	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Maintenance records Facility inspection Interviews with staff

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C227	(c) Standard: Emergency procedures. The CAH assures the safety of patients in non-medical emergencies by – (1) Training staff in handling emergencies, including prompt reporting of fires, extinguishing of fires, protection and where necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;	Are fire and emergency drills conducted regularly? Do all staff know what they are supposed to do in case of an emergency such as a tornado or a blizzard? See also NAC 449.316	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Binder – CAH Fire Safety Plan ☐ Binder – CAH Disaster Plan ☐ Binder – CAH Bioterrorism Preparedeness Plan ☐ Staff training and inservice records (to validate training) Facility inspection Interviews with and disaster scenarios posed to staff
C228	(2) Providing for emergency power and lighting in the emergency room and for battery lamps and flashlights in other areas;	Does the emergency generator have adequate capacity to provide power for emergency equipment and lighting in the emergency room? Are there maintenance records and facility specific policies and procedures or test runs and frequency of test runs on emergency equipment?	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Binder – CAH Fire Safety Plan ☐ Binder – CAH Disaster Plan ☐ Maintenance records documenting test runs and frequence of test runs Facility inspection Interviews with staff
C229	(3) Providing for an emergency fuel and water supply; and	What arrangements have been made for fuel and water in the event normal sources are degraded? If hospital is heated with oil, be prepared to have a signed agreement from supplier that hospital will be considered "priority" customer in emergencies or shortage situations.	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Binder – CAH Fire Safety Plan ☐ Binder – CAH Disaster Plan ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C230	(4) Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.	Does the facility have policies and procedures in place that address the specific conditions for the area in which the CAH is located (e.g., snowbound facility, spring flooding)?	Written review & documentation of policies & procedures: ☐ Binder – CAH Maintenance/Physical Plant Policies and Procedures ☐ Binder – CAH Fire Safety Plan ☐ Binder – CAH Disaster Plan Facility inspection Interviews with staff
C231	(d) Standard: Life safety from fire. (1) Except as provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the LSC, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CCMS Information Resource Center, 7500 Security Boulevard, Baltimore MD and at the Office of the Federal Register, 800 North Capital Street NW Suite 700, Washington DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.	It is presumed that your facility is currently meeting life safety requirements – check to see that this is the case. CAH life safety codes (Tags C231-234) are no more demanding than current requirements. This revision adopts the 2000 edition of the LSC and deletes provisions for the use of roller latches in the facility. The entire building occupied by the CAH will be surveyed unless there is a 2-hour firewall separating the spaced designated as the CAH from the remainder of the building. A 2-hour floor slab does not count; it must be a vertical firewall to constitute a separate building or part of a building.	Facility inspection Interviews with staff
C232	(2) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.	This revision deletes "grandfathering" of older editions of the LSC and allows the use of a State code if approved by CMS.	Facility inspection Interviews with staff
C233	(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.	If available, waiver will be reviewed.	Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C234	(4) The CAH maintains written evidence of regular inspection and approval by State and local fire control agencies.		Written review & documentation of policies & procedures: ☐ Fire inspection reports Facility inspection
C235	(5) A CAH must be in compliance with the following provisions beginning on March 13, 2006 – (i) Chapter 19.3.6.3.2 exception number 2 (ii) Chapter 19.2.9 Emergency Lighting.	This section gives facilities until March 13, 2006 to replace roller latches and to replace 1 hour batteries with 1-1.5 hour batteries in emergency lighting systems that use batteries as power sources.	Facility inspection
C240	**§485.627 Condition of participation: Organizational Structure**	See also NAC 449.313	
C241	(a) Standard: Governing body or responsible individual. The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.	Have the facility's operating policies been updated to fully reflect its responsibilities as a CAH (e.g., responsibilities of mid-level providers, provision of required direct CAH services)? Is there evidence that the governing body is fully responsible for the operations? Is there evidence that the governing body has approved the effort to become a CAH ? These assurances are probably contained in board meeting minutes and/or general facility policies and procedures.	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ CAH Governing Body meeting agenda and minutes ☐ Binder – CAH Job Descriptions ☐ Form CMS-855 – to determine if there are any inconsistencies relative to demonstrated evidence of actual CAH operations Facility inspection Interviews with staff
C242	(b) Standard: Disclosure. The CAH discloses the names and addresses of – (1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with Subpart C of part 420 of this chapter;	Have ownership and address lists been updated to indicate that the administration and ownership of a CAH, per se?	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Job Descriptions
C243	(2) The person principally responsible for the operation of the CAH; and	This individual is typically the hospital administrator and/or CEO. The surveyors will simply want evidence that the "CAH Administrator" is the person principally responsible for the operation of the CAH and that responsibility has been approved by the hospital board.	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Job Descriptions

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C244	(3) The person responsible for medical direction.	Is there a designated medical director for the hospital? Are the duties and responsibilities of the medical director clearly spelled out. How are changes in medical direction in the CAH reported to the BLC? See also NAC 449.355	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Job Descriptions
C250	**§485.631 Condition of participation: Staffing and staff responsibilities**		
C251	(a) Standard: Staffing. (1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.	Is there either a doctor of medicine or osteopathy on staff with a PA, NP or CNS? Is there an organizational chart, showing staff physicians, mid-levels and nursing staff? If so, provide or prepare current documentation. See also NAC 449.358, NAC 449.361	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Job Descriptions Facility inspection Interviews with staff
C252	(2) Any ancillary personnel are supervised by the professional staff.	All ancillary personnel are supervised by the professional staff. Have organizational charts been kept current? If not, have an up-date (and date) organizational chart.	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Job Descriptions Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C253	(3) The staff is sufficient to provide the services essential to the operation of the CAH.	Staff coverage is sufficient to provide essential services at the facility (e.g., emergency services described at §485.618, direct services described at §485.635(b), and nursing services described at §485.631(d)? Are staffing records and census records compatible?	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Job Descriptions ☐ Current Staffing/Work Schedules Facility inspection Interviews with staff
C254	(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist or physician assistant is available to furnish patient care services at all times the CAH operates.	If the hospital operates outpatient clinics, a doctor of medicine or osteopathy, PA, NP, or CNS is physically present and prepared to treat patients. Outpatient clinics have specific, posted operating hours. You cannot staff a clinic with a receptionist whose job it is to call a practitioner to come in when a patient shows up	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Job Descriptions ☐ Current Staffing/Work Schedules Facility inspection/Interviews with staff
C255	(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.	Note: If a nurse practitioner is on duty in the CAH, both requirements at §485.631(a)(4) and (5) are met. However, if a physician assistant is on duty, §485.631 (a)(4) is met, but §485.631(a)(5) is not met unless a registered nurse, clinical nurse specialist or licensed practical nurse is also on duty. See sample policy C255	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Job Descriptions ☐ Current Staffing/Work Schedules Facility inspection/Interviews with staff
C256	(b) Standard: Responsibilities of the doctor of medicine or osteopathy. (1) The doctor of medicine or osteopathy –	See also NAC 449.358	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Medical Staff By Laws ☐ Credential files for physicians and mid-level providers ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C257	(i) Provides medical direction for the CAH's health care activities and consultation for the medical supervision of the health care staff;	There is a doctor of medicine or osteopathy on staff. That individual must perform all of the medical oversight functions described in §485.631(b). Surveyors will be looking for evidence that demonstrates that the doctor of medicine or osteopathy provides medical direction for the CAH's healthcare activities and is available for consultation and supervision of the CAH health care staff.	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Medical Staff By Laws ☐ Credential files for physicians and mid-level providers ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff, esp., medical staff and medical staff director
C258	(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH's written policies governing the services it furnishes.	Does a doctor of medicine or osteopathy participate in the development of policies governing services? Are these policies periodically reviewed by the doctor of medicine or osteopathy? See sample policy C258	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Governing Board By Laws ☐ Binder – CAH Medical Staff By Laws Facility inspection Interviews with staff
C259	(iii) In conjunction with the physician assistant and/or nurse practitioner member(s), periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and	Does the doctor of medicine or osteopathy periodically review patient records in conjunction with staff mid-level practitioners? Is there evidence of a periodic review of patient records by the CAH physician? See sample policy C259	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Medical Staff By Laws and any periodic review policies and procedures ☐ Review of open and closed medical records Facility inspection Interviews with staff
C260	(iv) Periodically reviews and signs the records of patients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.	Note: The CAH physician must review and sign all inpatient records for patients cared for by mid-level practitioners. The CAH physician is not required to review and sign all outpatient records for patients cared for by mid-level practitioners. What is the CAH policy regarding periodic reviews?	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Medical Staff By Laws and any periodic review policies and procedures ☐ Review of open and closed medical records Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C261	(2) A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances) to provide the medical direction, medical care services, consultation, and supervision described in this paragraph, and is available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are documented in the records of the CAH. A site visit is not required if no patients have been treated since the last site visit.	Is there evidenced of a doctor of medicine or osteopathy's provision of medical direction, medical care services, consultation, and supervision? How does the CAH ensure that the physician is available by telephone or radio contact for consultation, assistance, and/or patient referral?	Written review & documentation of policies & procedures: ☐ CAH Organizational Chart ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff
C262	(c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities. (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff –		Written review & documentation of policies & procedures: ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Facility inspection Interviews with staff, including NPs, CNSs, and/or PAs
C263	(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and	Mid-level providers will be interviewed to assess the extent to which NPs, CNSs, and/or PAs are involved in the policy development, execution, and periodic review? Are policies updated regularly? Are CAH policies for mid-levels consistent with Nevada standards of practice and requirements for NPs, CNSs, and/or PAs?	Written review & documentation of policies & procedures: ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Facility inspection Interviews with NPs, CNSs, and/or PAs
C264	(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patient's health records.	Do PAs, NPs, and/or CNSs participate with a doctor of medicine or osteopathy in the review of their patients' health records?	Written review & documentation of policies & procedures: ☐ Review of open and closed medical records Facility inspection Interviews with NPs, CNSs, and/or PAs
C265	(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:		Written review & documentation of policies & procedures: ☐ Review of open and closed medical records Facility inspection Interviews with NPs, CNSs, and/or PAs

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C266	(i) Provides services in accordance with the CAH's policies; and	Are all mid-levels knowledgeable regarding the hospitals policies and procedures? Do they understand the unique status of CAH?	Written review & documentation of policies & procedures: ☐ Review of open and closed medical records Facility inspection Interviews with staff
C267	(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH and assures that adequate patient health records are maintained and transferred as required when patients are referred.	Are there referral arrangements in place with higher level facilities, particularly with reference to OB, cardiac and trauma? Are all staff aware of referral agreements? Are all staff aware of EMTALA requirements? Are there policies that address transfer of records when patient is transferred? See sample policy C267 See sample transfer agreement	Written review & documentation of policies & procedures: ☐ Review of open and closed medical records ☐ Binder – CAH Agreements and Contracts – esp., transfer agreemetns Facility inspection Interviews with staff
C268	(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.	Does a policy require notification of a doctor of medicine or osteopathy when inpatients are admitted? Does your facility have a documented system of notification in place? See sample policy C268	Written review & documentation of policies & procedures: ☐ Review of open and closed medical records Facility inspection Interviews with staff
C270	**§485.635 Condition of participation: Provision of services.**	See also NAC 449.331 – 449.394	
C271	(a) Standard: Patient care policies. (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.	Would observance of staff in daily duties support adherence to policies and procedures. Do they reflect current thinking/literature in procedures? Are all of the regulatory required policies and procedures in place? What evidence indicates that patients are receiving care in accordance with written policies for health care services consistent with Nevada law?	Written review & documentation of policies & procedures: ☐ Binder – CAH Patient Services Policies and Procedures ☐ Review of open and closed medical records Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C272	(2) The policies are developed with the advice of a group of professional personnel that includes one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1); at least one member is not a member of the CAH staff.	Physician is involved in and approves all clinical policies. Policies and procedures have been approved by a committee composed of clinical staff of CAH and at least one non-staff professional.	Written review & documentation of policies & procedures: ☐ Binder – CAH Patient Services Policies and Procedures ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee ☐ Review of open and closed medical records Facility inspection Interviews with staff
C273	(3) The policies include the following: (i) A description of the services the CAH furnished directly and those furnished through agreement or arrangement.	Do policies clearly explain what type of health care services are available by staff, which are furnished through agreements or arrangements? Arrangements and/or agreements include services provided through formal contracts, joint ventures, informal agreements, or lease arrangements. Additional services furnished through referral should be clearly described in statements such as "arrangements have be made with hospital X for CAH patients to receive the following services x, y, z ..."	Written review & documentation of policies & procedures: ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff
C274	(ii) Policies and procedures for emergency medical services.	Do policies show what emergency services requirements are provided by staff, by contract, by consultant, by transfer? Do policies define an "appropriate medical screening examination" and who can do it? See also NAC 449.349, NAC 449.331	Written review & documentation of policies & procedures: ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee ☐ Binder – CAH Agreements and Contracts ☐ Binder – Emergency Department Policies and Procedures Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C275	(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.	Are all practitioners credentialed? Have protocols been developed for mid-levels? Are privileges detailed and specific? Are policies clear on which mid-level practices require direct "over the shoulder" supervision, which require adherence to specific protocols and which allow independent judgement? Regardless of the format used by the CAH for its medical management guidelines, they should include the following essential elements: (a) They should be comprehensive enough to cover most health problems that patients usually refer to a physician; (b) They should describe the medical procedures available to the mid-levels in the facility; (c) They should describe the medical conditions, signs, or developments that require consultation or referral; and (d) They should be compatible with Nevada law. Surveyors will be looking for evidence that the CAH's guidelines for medical management of health problems accurately reflect the actual clinical capabilities of the facility and that medical guidelines are followed.	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Medical Records Policies and Procedures ☐ Binder – CAH Medical Staff By Laws and other guidelines for medical management ☐ Credential files for physicians and mid-level providers Interviews with staff, medical staff, and mid-level providers
C276	(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.	Are there policies (and practices) ensuring that storage handling, dispensing and administration of drugs and biologicals are in accordance with accepted professional principles? Are there inventory records and records of receipt and disposition? Are there procedures in place for handling of outdated, mislabeled or degraded drugs and biologicals? "In accordance with accepted professional principles" means patient care standards promoted by national, State, and local professional associations regarding clinical use of drugs and biologicals. This encompasses control procedures, proper labeling, and disposal procedures. See also NAC 449.343, NAC 449.373	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Pharmacy Policies and Procedures Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C277	(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.	Are there written procedures which require that medication errors and adverse drug reactions be reported immediately to the practitioner who ordered the drug? Are medication errors entered into the patient's medical record? Are unexpected or significant adverse drug reactions reported to the Food and Drug Administration?	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Pharmacy Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C278	(vi) A system for identifying, reporting, investigating and controlling infectious and communicable diseases of patients and personnel.	What is the hospitals nosocomial infection rate? Is there an active surveillance program of specific measures for prevention, early detection, control, education and investigation of infections and communicable disease? Is there a mechanism to evaluate the program(s) and take corrective action? Does the hospital follow the current recommendations of the CDC relative to specific infection(s) and communicable disease(s)? Are there systems in place to identify, report, investigate and control infectious and communicable diseases? Are there procedures to resolve identified problems involving infections and communicable diseases within the facility? Are there current minutes showing ongoing and current activity by the infection control committee? How are health care workers (HCW) on staff (including part-time staff) educated about infections and communicable diseases? How are HCWs screened for communicable diseases? How are they evaluated when exposed to non-treated communicable diseases? Surveyors will be examining evidence that demonstrates that the CAH's infection control program is incorporated into the facility-wide quality assurance program and that the actual infection control process is consistent with stated infection control policies and procedures. See also NAC 449.322	Written review & documentation of policies & procedures: ☐ Binder – CAH Infection Control Policies and Procedures ☐ Binder – CAH QA Plan ☐ Infection and incidence reports ☐ Infection surveillance logs ☐ Infection control committee meeting minutes and agenda Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C279	(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §485.625(i) is met with respect to inpatients receiving post-hospital SNF care.	A CAh is not required to prepare meals itself and is free to obtain meals under contract with another supplier, but the CAH is responsible for the quality of arranged services on the same basis as if CAH employees had provided those services Are policies and procedures in place to govern the delivery of dietary services? Is there a registered dietitian on staff or under contract with the hospital? Is there a dietary manual? See also NAC 449.337 – 449.3395	Written review & documentation of policies & procedures: ☐ Binder – CAH Dietary Department Policies and Procedures, esp., current diet plans and approval of these plans by medical staff ☐ A sample of patient menus Facility inspection Interviews with staff
C280	(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.	Are patient care policies reviewed on an annual basis by the professional group described in §485.635(a)(2), i.e., by the facility's "CAH Committee" or "CAH Policies and Procedures Committee"? Note: Annual review is a new standard as a CAH.	Written review & documentation of policies & procedures: ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff
C281	(b) Standard: Direct services (1) General. The CAH staff furnishes as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.	"Direct services" refers to a minimum set of services at the CAH provided through the use of CAH personnel. Which diagnostic and therapeutic services are delivered by staff? Which are provided indirectly (i.e., by contractual arrangement). Are specific, written, and current contracts on file in the hospital? Do contracts show level and frequency of service to be provided? Do contracts address peripheral issues of arrangement (e.g., inservice education for staff, liability)?	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C282	(2) Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under Section 353 of the Public Health Service Act (42 U.S.C. 236(a)) (See the laboratory requirements specified in Part 493 of this Chapter) – (i) Chemical examination of urine by stick or tablet method or both (including urine ketones); (ii) Hemoglobin or hematocrit; (iii) Blood glucose; (iv) Examination of stool specimens for occult blood; (v) Pregnancy tests; and (vi) Primary culturing for transmittal to a certified laboratory.	In this section, basic laboratory services must be provided directly at the CAH in order to facilitate the immediate diagnosis and treatment of the patient. The CAH must have a current CLIA certificate for those tests required under this standard. See also NAC 449.373	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Laboratory Department Policies and Procedures ☐ Logs and other records contained in the laboratory ☐ Appropriate and current CLIA certificate Facility inspection Interviews with staff, esp., laboratory department manager and staff
C283	(3) Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law, and do not expose CAH patients or staff to radiation hazards.	Are radiologic services available as needed to meet the needs of patients? Does the hospital have a contract with a radiologist to provide direction to radiology department? Are there procedures in place providing for adequate shielding for patients, personnel and facilities? Are there policies for adequate storage, use, and disposal of radioactive materials? Are there periodic inspections, and prompt identification and correction of hazards? Is patient and staff exposure to radioactive hazards monitored? See also NAC 449.376 and NAC 449.377	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Radiology Department Policies and Procedures Facility inspection Interviews with staff, esp., radiology department manager and staff
C284	(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides as direct services, medical emergency procedures as a first response to common life-threatening injuries and acute illnesses.	Is one person responsible for ensuring the availability of emergency equipment and supplies? How are your emergency procedures documented? See also NAC 449.331, NAC 449.349	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Emergency Department Policies and Procedures Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C285	(c) Standard: Services provided through agreements or arrangements. (1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including –	Individual agreements or arrangements should be well-defined, but need not be contractual. They should describe routine procedures (e.g., for obtaining outside laboratory tests) and there should be evidence in the agreement or arrangement that the governing body is responsible for these services provided under agreement or arrangement. Surveyors will be checking to see how well defined these agreements are. Are contractual services well defined? Is there evidence in the agreement or arrangement that the governing body is responsible for these services provided under agreement or arrangement? Do agreements change as scope of services changes? See also NAC 449.331	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff
C286	(i) Inpatient hospital care;	Is there an arrangement or agreement with one or more hospitals to provide inpatient care to patients the hospital cannot handle (i.e., greater than 96 hours or acuity level beyond capabilities of CAH)? See sample Transfer Agreement	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts, including transfer agreements Facility inspection Interviews with staff
C287	(ii) Services of doctors of medicine or osteopathy; and	Are there arrangements or agreements with one or more doctors of medicine or osteopathy to meet its requirements at §485.631(b)?	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts Facility inspection Interviews with staff
C288	(iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH.	Are contracting or referring laboratories in conformance with CLIA requirements in 42 CFR Part 493 of this chapter? Are there arrangements or agreements for specialized diagnostic and clinical laboratory services that are necessary to provide care for its patients (e.g., MRI)?	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Laboratory Department Policies and Procedures Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C289	(iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.	If dietary services are contracted, does the contract allow for the provision of nutritional services that meet requirements in §485.635(a)(3)(vii) and (if it has swing-bed patients) per §485.25(i)?	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Binder – CAH Dietary Department Policies and Procedures Facility inspection Interviews with staff
C290	(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.	Do you have documentation which shows that: • Transferred patients were accepted and provided with inpatient care, as needed, at hospitals to which they were transferred? • Patients referred for diagnostic and/or laboratory tests had these tests performed as requested by the practitioner responsible for the patient? • Physicians and/or suppliers of services are providing services in the manner described in the arrangement or agreement? • This will require that your transfer agreement with other hospital allows you to at least periodically check these items <u>after</u> you transfer a patient. See sample transfer agreements in Appendix	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts ☐ Review of open and closed medical records Interviews with staff
C291	(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.	Is there a list of all services which are provided under contract? How current is this list?	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts Interviews with staff
C292	(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following – (i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements; and	Is the CAH administrator/CEO responsible for all services provided through arrangements or agreements?	Written review & documentation of policies & procedures: ☐ Binder – CAH Governing Body By Laws ☐ Binder – CAH Job Descriptions ☐ CAH Organizational Chart Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C293	(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.	Do all contracted services meet all of the appropriate Conditions of Participation and standards for contracted services? Note: Hospital contractors must meet all Medicare conditions of participation (e.g., non-discrimination compliance) and standards for contracted services.	Written review & documentation of policies & procedures: ☐ Binder – CAH Governing Body By Laws ☐ Binder – CAH Job Descriptions Interviews with staff and temporary staff
C294	(d) Standard: Nursing services. Nursing services must meet the needs of patients.	See also NAC 449.361 – 449.3628	
C295	(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.	Does an RN have overall responsibility for patient care services? Are specialized needs of patients considered and documented? Are staff assigned appropriately given census and acuity? Does care provided meet the needs of each patient? Are temporary nursing staff oriented and supervised?	Written review & documentation of policies & procedures: ☐ Binder – CAH Nursing Department Policies and Procedures ☐ Nursing staff/work schedules ☐ Review of open and closed medical records Facility inspection Interviews with DoN, nursing staff and temporary nursing staff to assess familiarity with CAH nursing requirements
C296	(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each SNF level of care in a swing-bed CAH.	Does a registered nurse supervise the nursing care for each patient? Are staffing schedules current? Do staffing schedules correlate to the number and acuity of patients, including swing-bed patients? Will staffing schedules demonstrate that acuity and numbers of patients are considered in staffing?	Written review & documentation of policies & procedures: ☐ Binder – CAH Nursing Department Policies and Procedures ☐ Nursing staff/work schedules ☐ Review of open and closed medical records Facility inspection Interviews with DoN, nursing staff and temporary nursing staff to assess familiarity with CAH nursing requirements

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C297	(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy or, where permitted by State law, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.	Be prepared to demonstrate that: • Drugs, biologicals, and intravenous medications are administered only with a proper order. • Policies and procedures for the administration of drugs, biologicals and intravenous medications are followed. • Standing orders are reviewed, updated and signed by the current medical staff. • The administration of drugs, biologicals and intravenous medications are regularly monitored for quality assurance purposes.	Written review & documentation of policies & procedures: ☐ Binder – CAH Nursing Department Policies and Procedures ☐ Nursing staff/work schedules ☐ Review of 6-12 nursing care plans ☐ Review of open and closed medical records Interviews with DoN, nursing staff and temporary nursing staff to assess familiarity with CAH nursing requirements
C298	(4) A nursing care plan must be developed and kept current for each patient.	Is there a complete and current nursing care plan for each patient? Is discharge planning consideration part of every patient evaluation? See also NAC 449.332	Written review & documentation of policies & procedures: ☐ Binder – CAH Nursing Department Policies and Procedures ☐ Nursing staff/work schedules ☐ Nursing care plans ☐ Review of open and closed medical records Interviews with DoN, nursing staff and temporary nursing staff to assess familiarity with CAH nursing requirements
C300	**§485.638 Condition of participation: Clinical records.**	See also NAC 449.379	
C301	(a) Standard: Records system. (1) The CAH maintains a clinical records system in accordance with written policies and procedures.	Does your facility's actual system of clinical records conform with the system described in your policies and procedures?	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C302	(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.	For CAH surveys that are conducted after the initial certification survey, a sample (at least 10% of the census and not more than 30)of CAH active and closed clinical records will be assessed to determine if records are prepared and maintained in accordance with the requirements of §485.638(2) and (4).	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C303	(3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.	Who is the hospital's designated person who oversees medical records maintenance and organization?	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff and medical records director
C304	(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable – (i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;	Surveyors will check to see that there are properly executed informed consent forms, medical history health status and care needs assessments, and summary in each record, as needed.	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C305	(ii) Reports of physical examinations, diagnostic and laboratory test results, including laboratory services, and consultative findings;	Are reports of physical examinations, diagnostic and laboratory test results, and consultative findings signed by the appropriate practitioner?	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C306	(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatments; and	Is "other pertinent information" at §485.638(a)(4)(iii), in appropriate records?	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C307	(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.	If rubber stamp or auto authenticated signatures are allowed, do policies and procedures provide for appropriate sanctions for unauthorized or improper use of computer codes or signature stamps? Is there a list of authorized signatures of doctors and mid-levels for medical record?	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Credential files for physicians and mid-level providers ☐ Review of open and closed medical records Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C308	(b) Standard: Protection of record information. (1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.	Does your facility have policies and procedures for the protection of record information and use? Are medical records physically secure? Are there policies to prevent unauthorized persons from gaining access to patient records? See sample policy C308 See also NAC 449.379	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Binder – CAH HIPAA Compliance Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C309	(2) Written policies and procedures govern the use and removal of records from the CAH and the condition for the release of information.	Are there policies addressing the removal of medical records from the hospital? Is it allowed? Is it disallowed? If allowed, under what circumstances? See sample policy C309	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C310	(3) The patient's consent is required for release of information not required by law.	No records are released without the patients consent or under appropriate legal authority.	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Interviews with staff
C311	(c) Standard: Retention of records. The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending preceding.	Are medical records retained in their original or legally reproduced form, for a period of at least 6 years? Facsimiles received on thermal sensitive paper is reproduced on to regular paper. Is there a policy which states all medical records will be retained at least six years? See sample policy C311	Written review & documentation of policies & procedures: ☐ Binder – CAH Medical Records Policies and Procedures ☐ Review of open and closed medical records Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C320	**§485.639 Condition of Participation: Surgical services.** Surgical procedure must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section.	Surveyors will check to see that hospital surgical services are characterized by: • Equipment and supplies sufficient so that the type of surgery conducted can be preformed in a manner that will not endanger the health and safety of the patient; • Operative and recovery areas limited in access; • Appropriate aseptic techniques in place; • Appropriate cleaning between surgical cases; • Suitable equipment available for rapid and routine sterilization of operating room materials; • Sterilized materials properly labeled, and stored in a manner to ensure sterility; • Operating room attire suitable for the kind of surgical cases performed. For example, persons working in the operating suite must wear clean surgical costumes in lieu of their ordinary clothing; and • Surgical costumes are to be designed for maximum skin and hair coverage. Surveyors will check to see whether the surgical department's policies and procedures which minimally address: • Resuscitative techniques; • Aseptic technique and scrub procedures; • Care of surgical specimens; • Appropriate protocols for all surgical procedures, specific or general in nature, and include a list of equipment, materials, and supplies to properly carry out job assignments; • The cleaning of operating rooms after each use; • Sterilization and disinfection procedures; • Acceptable operating room attire; • Care of anesthesia equipment; and • Special provision for infected or contaminated patients. See also NAC 449.385 and 449.388	Written review & documentation of policies & procedures: ☐ Binder – CAH Governing Body By Laws ☐ Binder – CAH Medical Staff By Laws ☐ Binder – CAH Surgery Department Policies and Procedures ☐ Review of open and closed medical records Facility inspection Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C321	(a) Standard: Designation of qualified practitioners. The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by – (1) A doctor of medicine or osteopathy, including an osteopathy practitioner recognized under section 1101(a)(7) of the Act; (2) A doctor of dental surgery or dental medicine; or (3) A doctor of podiatric medicine.	Are physicians or others performing surgical techniques appropriately credentialed? Does the operating room supervisor have a current list of approved procedures for each practitioner?	Written review & documentation of policies & procedures: ☐ Binder – CAH Surgery Department Policies and Procedures ☐ Binder – CAH Medical Staff By Laws ☐ Credential files for physicians and mid-level providers ☐ Review of open and closed medical records Interviews with staff
C322	(b) Standard: Anesthetic risk and evaluation. A qualified practitioner, as described in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner as described in paragraph (a) of this section.	Will surgical medical records confirm and acceptable pre-anesthesia evaluation done by the practitioner administering the anesthetic agent is in the chart? If laboratory studies were ordered as part of patient evaluation the lab work is should be part of the medical record. For general anesthesia, the evaluation should contain, at a minimum, a brief note regarding the heart and lung findings the day of surgery. Depending on the type of anesthesia and length of surgery, the postoperative check should include some or all of the following: Level of activity; respirations; blood pressure; level of consciousness; patient color; and wound/dressing assessment. See also NAC 449.388	Written review & documentation of policies & procedures: ☐ Binder – CAH Surgery Department Policies and Procedures ☐ Credential files for physicians and mid-level providers ☐ Review of open and closed medical records Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C323	(c) Standard: Administration of anesthesia. The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope of practice laws. (1) Anesthetics must be administered only by – (i) A qualified anesthesiologist; (ii) A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (iii) A doctor of dental surgery or dental medicine; (iv) A doctor of podiatric medicine; (v) A certified registered nurse anesthetist, as defined in §410.69(b) of this chapter; or (vi) An anesthesiologist's assistant, as defined in §410.69(b) of this chapter; or (vii) A supervised trainee in an approved educational program, as described in §413.85 or 413.86 of this chapter.	What policies and procedures does your facility have in place to govern the administration of anesthesia? Who is qualified to administer anesthesia? See also NAC 449.388	Written review & documentation of policies & procedures: ☐ Binder – CAH Surgery Department Policies and Procedures ☐ Credential files for physicians and mid-level providers ☐ Review of open and closed medical records Interviews with staff
C324	(2) In those cases in which a certified registered nurse anesthetist administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner. An anesthesiologist's assistant must be under the supervision of an anesthesiologist.	In all procedures where a CRNA administers anesthesia, the operating practitioner understands and agrees to supervise the anesthetist when applicable. Determine whether CAH regulations in conflict with state licensing regulations?	Written review & documentation of policies & procedures: ☐ Binder – CAH Surgery Department Policies and Procedures ☐ Credential files for physicians and mid-level providers ☐ Review of open and closed medical records Interviews with staff
C325	(d) Standard: Discharge. All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.	Are all patients discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure? Is this reflected in the medical record? Are there policies regarding discharge instructions for post-anesthetic patients? Surveyors will check to see if exceptions to this condition are made by the attending practitioner and documented in the clinical record.	Written review & documentation of policies & procedures: ☐ Binder – CAH Surgery Department Policies and Procedures ☐ Binder – Discharge Planning Policies and Procedures ☐ Review of open and closed medical records Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C326	(e) Standard: State exemption. (1) A CAH may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter form the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law. (2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.	**Note: Any exceptions to this standard must be submitted in writing to the Nevada FLEX Program, the Bureau of Licensure and Certification, and documented with the Nevada Office of Rural Health. The Nevada Rural Health Plan does not currently provide any exception to this standard.**	
C330	**§485.641 Condition of participation: Periodic evaluation and quality assurance review.**	Note: The following conditions regarding "yearly evaluation" would not be applicable at initial survey but the hospital must have a process to show that yearly evaluation will be done annually, as a CAH. See sample policy C330 See also NAC 449.314, 449.3152, and 449.317	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff
C331	(a) Standard: Periodic evaluation. (1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of –	Note: As a CAH there must be an annual evaluation of services. Are there quality assurance surveys and patient satisfaction surveys in place? See sample policy C330	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C332	(i) The utilization of CAH services, including at least the number of patients served and the volume of services;	Does yearly evaluation of services include a consideration of volume, number, and utilization of services?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff
C333	(ii) A representative sample of both active and closed clinical records; and	Yearly evaluation includes review of 10 percent of records. Who is responsible for the review of both active and closed records? How are records selected and reviewed? How does the evaluation process ensure that the sample of records is representative of services furnished? What criteria are utilized in the review of both active and closed records?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee ☐ Review of open and closed medical records Interviews with staff
C334	(iii) The CAH's health care policies.	Yearly evaluation and review includes medical-clinical policies of the hospital. What evidence demonstrates that the health care policies of the CAH are evaluated, reviewed, and/or revised as a part of the annual program evaluation? See sample policy C330	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff
C335	(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.	Can it be demonstrated that yearly evaluation results in follow-up and action where necessary? How does the CAH use the results of the yearly program evaluation? Were policies, procedures, and/or facility practices changed or revised as a result of the yearly program evaluation?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C336	(b) Standard: Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that –	The quality assurance program must be facility-wide, including all departments and all services provided under contract that includes: • Ongoing monitoring and data collection, • Problem prevention, identification and data analysis, • Identification of corrective actions, • Implementation of corrective actions, • Evaluation of corrective actions, and • Measures to improve quality on a continuous basis. Surveyors will be reviewing your facility's QA plan and all other documents you can provide regarding QA activities (e.g., meeting notes from QA committee meetings, QA reports) to determine the scope and structure of QA activities in your hospital.	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff, especially QA Director
C337	(1) All patient care services and other services affecting patient health and safety, are evaluated;	Is there is a designated quality assurance coordinator? Are patient care services and patient health and safety part of the quality assurance program? How is this information communicated to the medical staff and hospital board?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff, especially QA Director
C338	(2) Nosocomial infections and medication therapy are evaluated;	Are there an infection control officer, infection control committee and documented infection control processes?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Infection Control Log ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff, especially QA Director

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C339	(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;	Does a doctor of medicine or osteopathy evaluate the quality of care provided by mid-level practitioners? Is clinical performance of mid-level practitioners part of the quality assurance program? Is there provision for action if quality of care concerns are raised with regards to mid-levels? What follow-up actions are prescribed in your facility's QA plan?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff, especially QA Director
C340	(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by – (i) One hospital that is a member of the network when applicable; (ii) One QIO or equivalent entity; or (iii) One other appropriate and qualified entity identified in the	Does the hospital have a Memorandum of Understanding with the QIO? Is there is an agreement with another hospital for peer review? See Sample Agreement to Exchange Peer Review Services	Written review & documentation of policies & procedures: ☐ Binder – CAH Agreements and Contracts Interviews with staff, especially QA Director
C341	(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.	Is there a person designated as a QIO liaison who can go forward with HealthInsight's (Nevada QIO) findings and recommendations?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff, especially QA Director
C342	(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.	Can the quality assurance program demonstrate follow-up action, remedial and corrective?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff, especially QA Director

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C343	(iii) The CAH documents the outcome of all remedial action.	Is remedial action, once taken, is further monitored until positive outcomes are demonstrated?	Written review & documentation of policies & procedures: ☐ Binder – CAH Periodic Evaluation and Quality Assurance Plan ☐ Periodic Evaluation and QA Reports ☐ Meeting minutes and agenda – CAH Policies and Procedures Committee Interviews with staff
C344	**§485.643 Condition of participation: Organ, tissue, and eye procurement.**	In general, CAHs must have (a) organ, tissue, and eye procurement policies and procedures; (b) organ, tissue, and eye procurement agreements on file; and (c) evidence of staff education on organ, tissue, and eye procurement.	
C345	The CAH must have and implement written protocols that: (a) Standard: Incorporate an agreement with an OPO designated under 486 of this chapter, under which it must notify, in a timely manner, the OPO or third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for tissue and eye donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;	CAHs must inform the OPO of every death or imminent death in a hospital. When death is imminent the CAH must make referrals both before a potential donor is removed from a ventilator and while the potential donor's organs are still viable. CAHs may not use "batch reporting" for deaths by providing periodic lists of deaths, even if instructed to do so by the OPO. If a patient is transferred from one hospital to another, the receiving hospital is responsible for notification of the OPO. "Timely notification" means a CAH must contact the OPO by telephone early enough so that the OPO has sufficient time to assess the potential donor, obtain consent, etc. so the organs will remain viable while this process takes place. In addition, early enough means as soon as possible after an individual has died, has been placed on a ventilator due to a sever brain injury, or has been declared brain dead by appropriate medical staff. When death is imminent, the CAH must make the referrals both before a potential donor is removed from a ventilator and while the potential donor's organs are still viable.	Written review & documentation of policies & procedures: ☐ Binder – CAH Organ, Tissue and Eye Procurement Policies and Procedures ☐ Binder – CAH Agreements and Contracts, esp. the CAH-OPO agreement ☐ Review of closed medical records of patients who have died in the CAH in the past six months Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C345 continued		The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose.	
C346	(b) Standard: Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage an distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;	The regulation requires CAHs to have an agreement with at least one tissue bank and at least one eye bank. The OPO may serve as a "gatekeeper" receiving notification about every CAH death and must notify the tissue bank chosen by the CAH about potential tissue and eye donors. It is not necessary for a CAH to have a separate agreement with a tissue bank if it has an agreement with OPO to provide tissue procurement services; nor is it necessary for a CAH to have a separate agreement with an eye bank if its OPO provides eye procurement services. The regulation may be satisfied by a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the CAH. The CAH may continue to current successful direct arrangements with tissue and eye banks as long as the direct arrangement does not interfere with organ procurement. The CAH is not required to use the OPO for tissue and eye procurement but is free to have an agreement with the tissue bank and eye bank of its choice. The tissue banks and eye banks define "usable tissues" and "usable eyes."	Written review & documentation of policies & procedures: ☐ Binder – CAH Organ, Tissue and Eye Procurement Policies and Procedures ☐ Binder – CAH Agreements and Contracts, esp. agreements with at least one tissue bank and one eye bank ☐ Review of closed medical records of patients who have died in the CAH in the past six months Interviews with staff

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C347	(c) Standard: Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation:	It is the responsibility of the OPO to screen for medical suitability in order to select potential donors. Once the OPO has selected a potential donor, that person's family must be informed of the family's donation options. The requestor must be an OPO representative or a designated requestor. A "designated requestor" is defined as an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community. Ideally, the OPO and the CAH will decide together how and by whom the family will be approached. If possible, the OPO representative and a designated requestor should approach the family together.	Written review & documentation of policies & procedures: ☐ Binder – CAH Organ, Tissue and Eye Procurement Policies and Procedures ☐ Binder – CAH Agreements and Contracts, esp. the CAH-OPO agreement ☐ Review of closed medical records of patients who have died in the CAH in the past six months Interviews with staff and family members of deceased patients
C348	(d) Standard: Encourages discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;	Using discretion does not mean a judgement can be made by the hospital that certain families should not be approached about donation. CAHs should approach the family with the belief that a donation is possible and should take steps to ensure the family is treated with respect and care. The CAH's staff perception that a family's grief, race, ethnicity, religion, or socioeconomic background would prevent donation should never be used as a reason not to approach a family.	Written review & documentation of policies & procedures: ☐ Binder – CAH Organ, Tissue and Eye Procurement Policies and Procedures ☐ Binder – CAH Agreements and Contracts, esp. the CAH-OPO agreement ☐ Review of closed medical records of patients who have died in the CAH in the past six months ☐ CAH in-service training records or logs ☐ Complaint logs Interviews with staff and family members of deceased patients

TAG	REGULATION	ELEMENTS TO CONSIDER	EVIDENCE/SURVEYORS' FOCUS
C349	(e) Standard: Ensure that the CAH works cooperatively with the designated OPO, tissue bank, and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place; and (f) For purposes of these standards the term "Organ" means a human kidney, liver, heart, lung or pancreas.	Any individuals involved in a request for organ, tissue, and eye donations must be formally trained in the consent process. All appropriate CAH staff needs to be trained regarding donation issues and how to work with the OPO, tissue bank and eye bank. CAHs are required to cooperate with OPOs, tissue banks and eye banks in reviewing death records. This means that a CAH must develop a protocol which permits the OPO, tissue bank and eye bank access to death record information that will allow the OPO, tissue bank and eye bank to assess the CAH's donor potential, assure that all deaths or imminent deaths are being referred to the OPO in a timely manner, and to identify areas where the CAH, OPO, tissue bank, and eye bank staff performance might be improved.	Written review & documentation of policies & procedures: ☐ Binder – CAH Organ, Tissue and Eye Procurement Policies and Procedures ☐ Binder – CAH Agreements and Contracts, esp. the CAH-OPO agreement ☐ Review of closed medical records of patients who have died in the CAH in the past six months Interviews with staff

Special requirements for CAH provides of long-term care services (swing-bed)

TAG	REGULATION	ELEMENTS TO CONSIDER
C350	**§485.645 Special requirements for CAH provides of long-term care services (swing-bed).** A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-hospital SNF care, and to be paid for SNF-level services, in accordance with paragraph (b) of this section.	Note: CMS will consider CAH facilities that meet all but the Minimum Data Set (MDS) SNF requirements to be in substantial compliance with the CAH swing bed regulations. CMS still requires CAHs to complete a resident assessment and a comprehensive care plan for each SNF patient and document the assessment in the medical record. However, CMS will no longer require CAHs to use the MDS instrument for the residential assessments.
C351	(a) Eligibility. A CAH must meet the following eligibility requirements – (1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and (2) The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.	
C352	(b) Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997. These facilities must meet the following requirements – (1) Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions and limitations that were applicable at the time these approvals were granted. (2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and a swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section, and may not request reinstatement under paragraph (b)(1) of this section.	Not applicable in Nevada.
C355	(c) Payment. Payment for inpatient RCPH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level care of services is made in accordance with the payment provisions in §413.114 of this chapter.	

TAG	REGULATION	ELEMENTS TO CONSIDER
C360	(d) SNF services. The CAH is substantially in compliance with the following SNF requirements contained in Subpart B of part 483 of this chapter. (1) Resident rights (§483.10(b)(3) through (b)(6), (d), (e), (h), (j)(i)(vii) and (viii), (1), and (m) of this chapter); (2) Admission, transfer, and discharge rights (§483.12(a) of this chapter); (3) Resident behavior and facility practices (§483.13 of this chapter); (4) Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirement of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy; (5) Social services ((§483.15(g) of this chapter); (6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (d), and (e) of this chapter); (7) Specialized rehabilitative services (§483.45 of this chapter); (8) Dental services (§483.55 of this chapter); (9) Nutrition (§483.25(i) of this chapter).	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Most hospitals applying for CAH status probably do not meet these requirements at present. The following requirements must be met for approval as a CAH.
C361	**§483.10 Residents rights.** The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following: (b) Notice of rights and services. (3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. What are the hospital's capabilities regarding communicating with physically impaired patients? Hospital minimizes use of technical jargon in communicating with the resident or cognitively impaired person. What are the foreign language skills of hospital personnel? See sample policy C361

TAG	REGULATION	ELEMENTS TO CONSIDER
C362	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Is patients' informed consent to all treatments always demonstrated? Is information regarding advance directives and living wills or durable powers of attorney given to all patients over the age of 18? Is it understood that the right to consent includes the right to refuse? Is it understood that services will not be denied because of refusal of specific treatments in cases of refusal. When refusal of treatment brings about a significant change, the facility reassess the resident and institutes care planning changes.
C363	(5) The facility must – (i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of – (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. (6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's's per diem rate.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Are residents told in advance when changes will occur in their bills? Does the hospital inform the resident of services and related changes? Are patients advised on admission that certain services may not be covered and that they are personally responsible?
C364	(d) Free Choice – The resident has the right to -- (1) Choose a personal attending physician;	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The facility may seek alternative physicians for patients if physician of record is not in compliance with Conditions of Participation. The facility will not place barriers in the way of residents choosing their own physicians. For example, if a resident does not have a physician, or if the resident's physician becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his or her choice in finding another physician.

TAG	REGULATION	ELEMENTS TO CONSIDER
C365	(2) Be fully informed in advance about the care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Do patients receive information about their medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives?
C366	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Note: Incompetency is a legal not a medical determination. Residents are involved in decisions about care and treatment. If there are conflicts between a resident's right and the resident's health or safety, the facility must attempt to accommodate both the exercise of the resident's rights and the resident's health, including exploration of care alternatives through a thorough care planning process in which the resident participates.
C367	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality for his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when – (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Right to privacy is respected with whomever the resident wishes to be private. For example, privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room, or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility's administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents. Facility staff treats residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual's need for privacy. Only authorized staff directly involved in treatment should be present when treatments are given. People not involved in the care of the individual should not be present without the individual's consent while he/she is being examined or treated. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services.

TAG	REGULATION	ELEMENTS TO CONSIDER
C368	(h) Work. The resident has the right to – (1) Refuse to perform services for the facility; (2) Perform services for the facility, if he or she chooses, when (i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. All resident work, whether of a voluntary or paid nature, is part of the plan of care. A resident's desire for work is subject to discussion of medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, voluntary or paid work can be negotiated. Residents who are paid for work are paid the prevailing rate in the community for similar work.
C369	(i) Mail. The resident has the right to privacy in written communications, including the right to – (1) Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Delivery of mail or other materials is made to the resident within 24 hours of delivery by the postal service. Delivery of outgoing mail to the postal service is made within 24 hours.
C370	(j) Access and Visitation Rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following: (i) Any representative of the Secretary; (vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and (viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Existing visiting hours limitations may conflict with this provision. Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. Non-family visitors are also granted "immediate access" to the resident. An individual or representative of an agency that provides health, social, legal or other services to the resident has the right of "reasonable access" to the resident.
C371	(1) Personal Property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Surveyors will check to see that the resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. All residents' possessions, regardless of their apparent value to others, are treated with respect, for what they are and for what they may represent to the resident.

TAG	REGULATION	ELEMENTS TO CONSIDER
C372	(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The right of residents who are married to each other to share a room does not give a resident the right, or the facility the responsibility, to compel another resident to relocate to accommodate a spouse. When a room is available for a married couple to share, the facility must permit them to share it if they choose.
C373	**§483.12 Admission, transfer and discharge rights.** (a) Transfer and discharge: (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plan or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Transfer and discharge provisions significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility will not transfer or discharge the resident unless: • The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility; • The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; • The safety of individuals in the facility is endangered; • The health of individuals in the facility would otherwise be endangered; • The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or • The facility ceases to operate. To demonstrate that any of these events have occurred, the law requires documentation in the resident's clinical record.

TAG	REGULATION	ELEMENTS TO CONSIDER
C374	(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless – (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (iii) The safety of individuals in the facility is endangered; (iv) The health of individuals in the facility would otherwise be endangered.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, the facility conducts the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. Refusal of treatment will not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. If transfer is due to the fact that the resident's health improved to the extent that the transferred/ discharged resident no longer needed the services of the facility. Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered? Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? If so, determine differences between these residents and those who were transferred or discharged.
C375	(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (vi) The facility ceases to operate.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.
C376	(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by – (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.
C377	(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must – (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. (ii) Record the reasons in the resident's clinical record; and (iii) Include in the notice the items described in paragraph (a)(6) of this section.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.

TAG	REGULATION	ELEMENTS TO CONSIDER
C378	(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice may be made as soon as practicable before transfer or discharge when -- (a) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section. (b) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section; (c) The resident's health improves sufficiently to allow a more immediate transfer or discharge under paragraph (a)(2)(ii) of this section; (d) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or (e) A resident has not resided in the facility for 30 days.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.
C379	(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;(iv) A statement that the resident has the right to appeal the action to the State; (v) The name, address and telephone number of the State long term care ombudsman; (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally ill Individuals Act.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.

TAG	REGULATION	ELEMENTS TO CONSIDER
C380	(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence.
C381	**§483.13 Resident behavior and facility practices.** (a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	"Convenience" is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interest. Medical symptoms that would warrant the use of restraints must be reflected in the comprehensive assessment and care planning. For those residents whose care plans indicate the need for restraints the facility engages in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities.) In the case of a resident who is incapable of making a decision, the surrogate or representative exercises this right based on the same information that would have been provided to the resident. The surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, because a surrogate or representative has approved or requested them the facility will not use restraints in violation of the regulation solely. "Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as: • Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; • Tucking in a sheet so tightly that a bed bound resident cannot move; • Using wheel chair safety bars to prevent a resident from rising out of a chair; • Placing a resident in a chair that prevents rising; and • Placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails may be used to restrain residents or to assist in mobility and transfer of residents. The use of bed rails as restraints is Orthotic body devices may be used solely for therapeutic purposes to improve overall functional capacity of the resident.

TAG	REGULATION	ELEMENTS TO CONSIDER
C381 continued		Bed rails may be used to restrain residents or to assist in mobility and transfer of residents. The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Bed rails used as restraints add risk to the resident. They potentially increase the risk of more significant injury from a fall from a bed with raised bed rails than from a fall from a bed without bed rails. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Other interventions that the facility might incorporate in care planning include: • Providing restorative care to enhance abilities to stand safely and to walk; • A trapeze to increase bed mobility; • Placing the bed lower to the floor and surrounding the bed with a soft mat; • Equipping the resident with a device that monitors attempts to arise; • Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or • Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information. When used for mobility or transfer, assessment should include a review of the resident's: • Bed mobility (e.g., would the use of the bed rail assist the resident to turn from side to side? Or, is the resident totally immobile and cannot shift without assistance?): and • Ability to transfer between positions, to and from bed or chair, to stand and toilet (e.g., does the raised bed rail add risk to the resident's ability to transfer?). However, as with other restraints, for residents who have been restrained by bed rails, it is expected that the process facilities employ to reduce the use of bed rails as restraints is systematic and gradual (e.g., lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell.) Before a resident is restrained, the facility must demonstrate the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his or her highest level of physical and psychosocial well-being. Appropriate exercise, therapeutic interventions such as orthotic devices, pillows, pads, or lap trays often assist in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use. Restraints may not be used to permit staff to administer treatment to which the resident has not consented. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question.

TAG	REGULATION	ELEMENTS TO CONSIDER
C382	(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Residents are not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. "Abuse" is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. "Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. "Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. "Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. "Involuntary seclusion" is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

TAG	REGULATION	ELEMENTS TO CONSIDER
C383	(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must – (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The facility will do whatever is within its control to prevent mistreatment, neglect, and abuse of resident or misappropriation of their property. Facility policies include, but are not limited to, identification of residents whose personal histories render them at risk for abusing other residents. Assessment of appropriate intervention strategies to prevent occurrences. Monitoring resident for any changes that would trigger abusive behavior. Reassessment of the strategies on a regular basis. Facility policies call for disciplining up to discharge and/or filing of criminal complaints for staff abuse.
C384	(ii) Not employ individuals who have been – (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the officials in accordance with State law through established procedures (including the State survey and certification agency). (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. (4) The results of all investigations must be reported to the administrator or his designed representative and to other officials in accordance with Sate law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Facility does a thorough investigation of the past histories of individuals they are considering hiring. In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility will check all references and make reasonable efforts to uncover information about any past criminal prosecutions. An aide or other facility staff found guilty of neglect, abuse , or mistreating residents or misappropriation of property by a court of law, will have his or her name entered into the nurse aide registry, or reported to the licensing authority, if applicable. Further, if actions by a court of law against an employee are such that they indicate that the individual is unsuited to work in a nursing home (e.g., felony conviction of child abuse, sexual assault, or assault with a deadly weapon), the hospital will report that individual to the nurse aide registry (if a nurse aide) or to the State licensing authority (if a licensed staff member). Such a determination is not limited to mistreatment, neglect and abuse of residents and misappropriation of their property, but to any treatment of residents or others inside or outside the facility which the facility determines to be such that the individual should not work in a nursing home environment.

TAG	REGULATION	ELEMENTS TO CONSIDER
C385	**§483.15 Quality of Life.** A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (f) Activities. (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who – (i) Is a qualified therapeutic recreation specialist or an activities professional who – (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Surveyors will determine whether there is an activities program that: • Provides stimulation or solace; • Promotes physical, cognitive and/or emotional health; • Enhances to the extent practicable, each resident's physical and mental status; and • Promote each resident's self-respect by providing activities that support self-expression and choice. Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers, and visitors. Surveyors may request the following types of documentation: • Activities schedules; • Clinical records and activity attendance records; and • Care plans

TAG	REGULATION	ELEMENTS TO CONSIDER
C386	(g) Social Services. (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Surveyors will determine whether the facility provides for the medically-related social services needs of each resident. Does the facility aggressively identify the need for medically-related social services, and pursue the provision of these services? "Medically-related social services" means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example: • Making arrangements for obtaining needed adaptive equipment, clothing, and personal items; • Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning; • Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications; • Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation); • Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements); • Building relationships between residents and staff and teaching staff how to understand and support residents' individual needs; • Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality; and • Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions. Factors with a potentially negative effect on physical, mental, and psychosocial well-being include an unmet need for: • Dental/denture care; • Podiatric care; • Eye care; • Hearing services; • Equipment for mobility or assistive eating devices; and • Need for home-like environment, control, dignity, privacy.

TAG	REGULATION	ELEMENTS TO CONSIDER
C386 continued		Where needed services are not covered by the Medicaid State Plan, the facility still attempts to obtain these services. For example, if a resident requires transportation services that are not covered under a Medicaid State Plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer assistance. Types of conditions to which the facility should respond with social services by staff or referral include: • Lack of an effective family/social support system; • Behavioral symptoms; • If a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior; • Presence of a chronic disabling medical or psychological condition (e.g., multiple schizophrenia); • Depression; • Chronic or acute pain; • Difficulty with personal interaction and socialization skills; • Presence of legal or financial problems; • Abuse of alcohol or other drugs; • Inability to cope with loss of function; • Need for emotional support; • Changes in family relationships, living arrangements, and/or resident's condition or functioning; and • A physical or chemical restraint.

TAG	REGULATION	ELEMENTS TO CONSIDER
C388	**§483.20 Resident assessment.** The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. (b) Comprehensive assessment. (1) The facility must make a comprehensive assessment of a resident's needs which – (i) Is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and (ii) Describes the resident's capability to perform daily life functions and significant impairments in functional capacity. (2) The comprehensive assessment must include at least the following information – (i) Medically defined conditions and prior medical history; (ii) Medical status measurement; (iii) Physical and mental functional status; (iv) Sensory and physical impairments; (v) Nutritional status and requirements; (vi) Special treatments or procedures; (vii) Mental and psychosocial status; (viii) Discharge potential; (ix) Dental condition; (x) Activities potential; (xi) Rehabilitation potential; (xii) Cognitive status; and (xiii) Drug therapy.	Note: CMS will consider CAH facilities that meet all but the Minimum Data Set (MDS) SNF requirements to be in substantial compliance with the CAH swing bed regulations. CMS still requires CAHs to complete a resident assessment and a comprehensive care plan for each SNF patient and document the assessment in the medical record. However, CMS will no longer require CAHs to use the MDS instrument for the residential assessments.

TAG	REGULATION	ELEMENTS TO CONSIDER
C389	(4) Frequency. Assessments must be conducted – (i) No later than 14 days after the date of admission; (ii) For current NF residents not later than October 1, 1991; (iii) For current SNF residents, not later than January 1, 1991; (iv) Promptly after a significant change in the resident's physical or mental condition; and (v) In no case less often than once every 12 months.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Patients are assessed not later than 14 days after admission. "Admission" to be the facility is defined as an initial stay or a return stay (not a readmission) in the facility. A return stay applies to those residents who are discharged without expectation that they will return to the facility, but who do return to the facility. A "readmission" is an expected return to the facility following a temporary absence for hospitalization, off-site visit or therapeutic leave. A resident who is readmitted and for whom there is a prior RAI on file does not require a new assessment unless a significant change in status has occurred (see below), and should remain on the same schedule as if there had been no temporary absence. "Promptly" means that once it is determined that the resident's change in status is significant or likely to be permanent, a full assessment must be completed within 14 days of this determination. A "significant change" is a major change in the resident's status that is not self-limiting, impacts on more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. According to this definition, a significant change reassessment would be indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement.
C390	(iv) Promptly after a significant change in the resident's physical or mental condition; and	If a resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change assessment. Facilities may correct errors on the MDS per CMS policy within 7 days of its completion. "Promptly" means that once it is determined that the resident's change in status is significant or likely to be permanent, a full assessment must be completed within 14 days of this determination. "Significant change" is a major change in the resident's health status that is not self-limiting, impacts on more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. According to this definition, a significant change reassessment would be indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement.
C391	(v) In no case less often than once every 12 months.	

TAG	REGULATION	ELEMENTS TO CONSIDER
C392	(5) Review of Assessments. The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The intent of this condition is to assure that the resident's assessment is accurate and reflects the resident's current status.
C393	(6) Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (d) of this section.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.
C394	(7) Coordination. The facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The intent of this regulation is to prevent duplication in data gathering by using MDS assessment information for more than one purpose.
C395	(d) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following -- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psycho- social well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. An interdisciplinary team, in conjunction with the resident, resident's family, surrogate or representative, as appropriate, develops quantifiable objectives for the highest level of functioning the resident may be expected to maintain, based on the comprehensive assessment. The interdisciplinary team shows evidence in the RAP Summary or clinical record of the resident's status in triggered RAP areas and their rationale for deciding whether to proceed with care planning and that they considered the development of care planning interventions for outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to follow resident progress. Facilities may, for some residents, need to prioritize needed care. This should be noted in the clinical record or on the plan of care. The requirements reflect the facility's responsibility to provide necessary care and services to attain or maintain the highest practicable physical, mental or psychosocial well-being, in accordance with the comprehensive assessment and plan of care. However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. The desires of the resident should be documented in the clinical record.

TAG	REGULATION	ELEMENTS TO CONSIDER
C396	(2) A comprehensive care plan must be – (i) Developed within 7 days after the completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. • Do treatment objectives have measurable outcomes? • Does the care plan reflect standards of current professional practice? • Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment. • Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment. • If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? A comprehensive care plan is developed within 7 days of the completion of the assessment.
C397	(3) The services provided or arranged by the facility must – (i) Meet professional standards of quality; and	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.
C398	(ii) Be provided by qualified persons in accordance with each resident's written plan of care.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The hospital has recommended practices to achieve desired resident outcomes. These may include: • Current manuals or textbooks on nursing, social work, physical therapy, and so forth. • Standards published by professional organizations such as the American Nurses' Association, the National Association of Social Work, the American Dietetic Association, the National Association of Activity Professionals, the American Medical Association, and so forth. • Clinical practice guidelines published by the Agency for Health Care Policy and Research. • Current professional journal articles.

TAG	REGULATION	ELEMENTS TO CONSIDER
C399	(e) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes – (1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. A post-discharge plan of care for an anticipated discharge is done for each resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for mentally retarded individuals. A "post-discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community. "Anticipates" means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident's death. "Adjust to his or her living environment" means that the post-discharge plan, as appropriate, should describe the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple care givers. It should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/care giver education needs to ensure the resident/care giver is able to meet care needs after discharge.
C400	**§483.25 Quality of Care.** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. (i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident – (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.

TAG	REGULATION	ELEMENTS TO CONSIDER
C401	(2) Receive a therapeutic diet when there is a nutritional problem.	Suggested parameters for evaluating significance of unplanned and undesired weight loss are: Interval — Significant Loss — Severe Loss 1 month — 5% — Greater than 5% 3 months — 7.5% — Greater than 7.5% 6 months — 10% — Greater than 10% The following formula determines percentage of loss: % of body weight loss = usual weight - actual weight / usual weight x 100. In evaluating weight loss, consider the resident's usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food? Some laboratories may have different "normals." Determine range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident's clinical condition and baseline normal values. Note: There is no requirement that facilities order the tests references above. Clinical Observations: Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting.

TAG	REGULATION	ELEMENTS TO CONSIDER
C402	**§483.45 Specialized rehabilitative services.** (a) Provision of services. If specialized rehabilitative services such as, but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must -- (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. "Specialized rehabilitative services" are differentiated from restorative services which are provided by nursing staff. They include: • Physical therapy, • Occupational therapy, • Speech/Language pathology therapy, and • Rehabilitative services for MI and MR Specialized rehabilitative services are provided by or coordinated by qualified personnel. Specialized rehabilitative services provided to residents who need them even when the services are not specifically enumerated is the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.
C403	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. Specialized rehabilitative services are provided for individual's under a physician's order by a qualified professional.
C404	**§483.55 Dental services.** The facility must assist residents in obtaining routine and 24-hour emergency dental care.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. The facility is directly responsible for the dental care needs of its residents. The facility must ensure that a dentist is available for residents (i.e., employ a staff dentist or have a contract (arrangement) with a dentist to provide services). For Medicare and private pay residents, facilities are responsible for having the services available, but they may impose an additional charge for the services. For all residents of the facility, if they are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems so that the resident is able to maintain his/her highest practicable level of well-being.
C405	(a) Skilled nursing facilities. A facility – (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; (2) May charge a Medicare resident an additional amount for routine and emergency dental services;	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.

TAG	REGULATION	ELEMENTS TO CONSIDER
C406	(3) Must if necessary, assist the resident – (i) In making appointments, and (ii) By arranging for transportation to and from the dentist's office; and (4) Promptly refer residents with lost or damaged dentures to a dentist.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds. "Routine dental services" means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodonic procedures, (e.g, taking impressions for dentures and fitting dentures). "Emergency dental services" includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity, appropriately treated by a dentist that requires immediate attention. "Prompt referral" means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.
C407	(b) Nursing facilities. The facility – (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident; (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.
C408	(2) Must, if necessary, assist the resident – (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (3) Must promptly refer residents with lost or damaged dentures to a dentist.	Note: This item is a necessary element of approval as a CAH for patients in swing-beds.